Anthrax and Smallpox: Comparison of Two Outbreaks

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Abstract

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Anthrax and Smallpox: Comparison of Two Outbreaks

• 1979 Sverdlovsk anthrax epidemic, officially explained by consumption of infected meat; military aerosol suspected

• 1972 Yugoslavia smallpox epidemic, started by a pilgrim returning from Mecca via Baghdad, site of unreported outbreak
Key Problem = Late Diagnosis

1. What are the political causes?
2. What are the medical/professional causes?
3. What are the public communication causes?
1979 Sverdlovsk Epidemic

1992-1994 investigation of an “unnatural” outbreak of inhalational anthrax
Sources of Evidence

- KGB list of 64 victims’ names and addresses
- Interviews with families/neighbors of 56 victims
- Cemetery data
- Autopsy tissue data
- Hospital records (5 survivors)
- Local hospital and factory clinic lists
- Veterinary documents/animal deaths
April 4-May 16, 1979 cases reported as due to eating infected meat over weeks. Fatalities 64, survivors 15.
Anna Komina
Ceramics factory worker, age 54;
resident of affected district

Date of onset of symptoms: April 4
Date of death: April 10
Valentin Petrovich Borisov  
Age 27, Soldier, Compound 32

Pyotr Pilyasov, Age 39  
Construction worker
June, 1992, Hospital 20, in Ekaterinburg’s southern Chkalovsky district. Team members Martin Hugh Jones, veterinarian, Alexis Shelokov, virologist, and Matthew Meselson, biochemist and team organizer, with a university host V. A. Shpetkin, and the hospital director, Margarita Ilyenko.
Street leading towards ceramics factory (smokestack in Center) where 18 workers died of anthrax, April-May 1979
1993. Interior of pipe shop of abandoned ceramics factory. Large, third-story windows on left face northwest.
Gate of Compound 19 military base, southwest Ekaterinburg. Soldier is allowing truck to enter.
Cottage in village southeast of Ekaterinburg where animals died of anthrax in 1979, starting April 5-6, and where villagers were vaccinated and quarantined.
Sverdlovsk, c.1985
Red dots=Nighttime
Locations of victims.
Addresses obtained from
KGB and other lists.
Southern cluster is in
Chkalovsky rayon.
Arrows=homes off map.
Chkalovsky District Only
(note inset of entire city)

Irregular white lines show Compounds 19 and 32.

White rectangle indicates Ceramics factory.

Red dots=daytime locations of 66 victims and 11 survivors.
Six villages southeast of Sverdlovsk where 1979 epizootic occurred. Public health measures April through May. Interviews conducted at F, Abramovo, confirmed Veterinary documents.
Research Findings

• A lethal emission of anthrax spores from Compound 19 occurred during the afternoon of April 2, 1979.
• No young people under 24 or children were affected.
• Approximately 80 people (of some 5000 exposed) became infected; 11 survived with treatment.
• An estimated gram (a trillion spores) caused the fatalities; attack rate of 1-2%; fatality rate around 80% (note late diagnosis).
• Inhalation anthrax in humans can occur as long as 43 days after exposure. (First evidence in human cases)
Soviet Public Health Response

• Urban: lab diagnosis, screening for central hospital intensive care and pediatric cases, ambulance transport, autopsy team; 4000 volunteers mobilized for disinfection and distribution of antibiotics; Moscow clinical team, vaccine campaign for 50,000; building exteriors washed.

• Rural: roadblocks, carcasses burnt, enforced human vaccination, animal sheds destroyed, 3-week village quarantine.
Diagnosis 9 days post April 2 exposure
Total 21 deaths

Moscow doctors April 12 arrival.
Total 25 deaths

17 victims die with no hospital care

City clean-up begun.
30,000 vaccinated.
April 16,
Total 42 deaths

Last recorded death May 16.
Total 66 valid cases
11 survivors
Smallpox Epidemic
Yugoslavia, 1972

Imported Virus Contagion
“Natural Outbreak”
Fig. 1.3. The clinical course of moderately severe ordinary-type variola major in an unvaccinated subject (A); inoculation smallpox (variolation) in an unvaccinated subject (B); and primary vaccination (C). (Temperature records from an illustration in Hime (1896) with modified wording.)
Fig. 23.5. Spread of smallpox in Iran, Iraq and the Syrian Arab Republic, 1970–1972. The disease was introduced from Afghanistan into Mashhad, Iran, in October 1970. There were three waves of dispersion through Iran, which lasted over a period of 22 months. By the end of 1971 smallpox had crossed into Iraq, where it spread north to Arbil and south to As Samawah. Transmission in Iraq was interrupted by June 1972. In February 1972, smallpox spread from Baghdad in Iraq to Meyadin in the Syrian Arab Republic, where a smaller outbreak occurred that was contained by June 1972.
 Feb. 3-7 index case infected in Baghdad.
 Feb.15-16 falls ill at home Danjani (Kosovo)

 Mar.5 one of 11 infected by index case falls ill in Serbia
 Mar.10 Serbian dies after infecting 42 in hospital
 Mar.11, Serbia case total 10, Kosovo 12
 Mar.13 physician in Kosovo sounds alert

 **Mar.17 diagnosis and state containment initiative**
 Mar.25 case total is 137
 April 15 case total is 173
 (123 Kosovo, 48 Serbia, 1 Vojvodina, 1 Montenegro)
Fig. 4.8. The interval between the first possible exposure to a case of smallpox imported into Europe by air and the onset of symptoms in first generation indigenous cases, in family and hospital environments. (Based on Mack, 1972.)
Fig. 23.7  Yugoslavia: number of cases of smallpox, by date of onset and locality, 1972. The first generation of cases occurred in Kosovo province and adjacent areas; the large second generation in Kosovo, Belgrade and some other places.
Public Health Response
Mar. 15 to May 9
Vaccine campaign, Quarantine, roadblocks. Belgrade team joins Kosavar local health staff (rural, many migrant workers) to begin concentric circles of Vaccinations in 25 foci, with family and village quarantine, prohibition of public meetings.
18 million (of 20.8 million citizens) were vaccinated in 3 weeks. 175 cases, 35 dead (20%) case fatality rate. 37% of cases among previously vaccinated.
Structural Sources of Late Diagnosis

- Political: military secrecy/religious repression
- Medical/Professional: lack of familiarity with disease (misdiagnosis)
- Communication: public uneducated about risk
Solutions to Late Diagnosis

1. Political-public health cooperation
2. Medical technology and education
3. Accurate public communication